Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2014	2014_303563_0024	L-000878-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

CHATEAU GARDENS ELMIRA LONG TERM CARE CENTRE
11 Herbert Street, Elmira, ON, N3B-2B8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELANIE NORTHEY (563), JULIE LAMPMAN (522), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 28 - August 7, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Environmental Manager, the Social Worker, one Corporate Nurse Consultant, six Registered Practical Nurses (RPN), two Registered Nurses (RN), seven Personal Support Workers, the Resident Council President, forty Residents, one Environmental Service worker, and one Dietary Aide.

During the course of the inspection, the inspector(s) conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. Observation of the bed system on July 28, 2014 at 1330 hrs. for resident # 53 revealed one half rail in use on the left side of the bed and keepers absent from the foot of the bed.
Interview with the Environmental Manager on July 28, 2014 at 1430 hrs. confirmed resident # 53 bed system does not have mattress keepers affixed to the foot of the bed frame and keepers should be installed to prevent the mattress from slipping.
Record review of the "Bed Entrapment Log" for resident # 53 revealed a corrective action of "4 keepers" dated February/2014. Only the head of the bed had keepers in place on July 28, 2014.
Environmental Manager added keepers to the foot of the bed on July 28, 2014 for resident # 53.

B. Observation of the mattress on July 29, 2014 for resident # 15 revealed that the mattress did not fit the bed properly. The mattress was too large and did not stay stationary within the keepers.

Record review of the "Facility Entrapment Inspection Sheet" for resident # 15 dated November 14, 2012 revealed fails in zones 2 and 4 where the home identified "rail older matt" as the reason for failure. The "Bed Entrapment Log" dated February/2014 revealed a corrective action of "4 keepers" and the "Bed Entrapment Log" dated July 24, 2014 revealed no corrective action to replace the old mattress.

The Acting Director of Care confirmed the mattress for resident # 15 was too large for the bed and an entrapment risk to the resident. The Administrator confirmed that the bed was a risk for resident bed entrapment.

C. Observation of air mattress on July 28, 2014 at 1400 hrs. for resident # 3 revealed it did not fit the bed frame and there was a gap greater than 4.5 " between the head board and the mattress of the bed.
Observation on July 28, 2014 at 1600 hrs. revealed the air mattress for resident # 3 had been fixed so that the air mattress fits the frame of the bed. (538)

D. Record review of the "Facility Entrapment Inspection Sheet" dated November 14, 2012 revealed multiple fails in zones 2, 3 and 4 for multiple residents where the home

identified "older matt" as the reason for most of these failures.

Record review of the "Bed Entrapment Log" revealed corrective action was completed February 2014 and July 24, 2014. This was 15 - 20 months after the failed bed systems were identified. No documentation of corrective actions taken after the November 14, 2012 entrapment inspection.

Observation of the "Facility Entrapment Inspection Sheet" and the "Bed Entrapment Log(s)" revealed once corrective action was taken, an inspection for bed entrapment was not completed to ensure interventions were effective in correcting the failed zones identified on the November 14, 2012 inspection sheet.

Documentation provided by the Environmental Manager proved inconsistent across all bed entrapment logs given to inspector # 563 on July 28, 2014. For example, the documentation for the bed system in room S201 bed 4 revealed:
- the "Facility Entrapment Inspection Sheet" dated November 14, 2012 identified the mattress had 4 keepers and the reason for the fail in zone 2 and 4 was due to “older matt”
- the "Bed Entrapment Log" dated “Feb/14” indicates a corrective action of “4 keepers”

- the "Bed Entrapment Log" dated July 24, 2014 indicates a pass in only zone 4 with no documented corrective action.

It was unclear in the documentation provided that steps were taken to prevent resident entrapment in all bed systems and that after corrective action was taken each bed system was re-evaluated to ensure safety for the resident. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure the home is a safe and secure environment for its residents.

Observation of elevator from second floor entrance revealed dietary food cart with used kitchen utensils covered in food on top of the cart, a dish of what appeared to be butter on top of the cart and food present in the cart compartments left unattended on the elevator.

Administrator confirmed it is the home's process that the Dietary Aide board the food cart unattended in the elevator, press “B” and call the kitchen to alert them of the food carts arrival to the kitchen area. The Administrator shared no resident has ever accessed the cart or its contents while in the elevator because the residents are eating their meal at the time the cart is transported to the kitchen.

Inspector # 563 boarded elevator on first floor to discover a cart with clean dishes, kitchen containers and cutlery left unattended in the elevator. The cart had 21 butter knives accessible to anyone using the elevator, including residents.

Interview with registered staff confirmed the cart should not be left unattended in the elevator.

Interview with the Administrator confirmed it is the home's expectation that the kitchen cart not be left unattended in the elevator with utensils and cutlery accessible to residents.

Observation by inspector # 522 revealed a Dietary Aide loaded a Cambro food cart onto the elevator on second floor. Inspector then boarded the elevator 5 minutes later and the food cart with used serving utensils was still inside unattended. (522)

Dietary staff confirmed that he/she had loaded the food cart onto the elevator, called the kitchen to alert them that the cart was coming down and kitchen staff did not retrieve food cart from elevator.(522)

Administrator shared a memo had been posted for all Dietary staff to accompany all food and service carts when being returned or delivered to / from the kitchen. [s. 5.]

2. Observation of the 2nd floor tub room revealed the door to the tub room was wide open. The tub was filled with water.

Acting Director of Care (ADOC) stated "it is my fault, I told the Personal Support Worker (PSW) to leave the tub room door open because I knew you would want to see it."

Staff confirmed that it the home's expectation that residents have privacy during their bath and the door remains locked at all times. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Record review of the Care Plan for resident # 2 revealed goals and strategies were absent to address the resident's compromised verbal skills, decreased level of understanding and hearing difficulty.

Record review of the Minimum Data Set (MDS) Assessment for resident # 2 revealed the Communication Resident Assessment Profile (RAP) will be care planned regarding communication abilities.

Interview with registered staff confirmed that there is no communication section in the Care Plan or Kardex that identifies strategies to address compromised communication, hearing loss, decreased level of understanding / being understood or speech clarity.

2. Record review of the Care Plan for resident # 16 revealed goals and strategies were absent to address the resident's problem making self understood and understanding others as identified in the Communication RAP.

Record review of the MDS Assessment for resident # 16 revealed the Communication RAP will be care planned regarding resident's current level of communication.

Interview with registered staff confirmed that there is no communication section in the Care Plan or Kardex that identifies strategies to address the communication problem of making self understood and understanding others for resident # 16. [s. 6. (1) (a)]

3. Review of the MDS Assessments for resident # 29 revealed the Mood State RAP triggered. The RAP indicated that mood was addressed in the resident's care plan.

Review of the Care Plan for resident # 29 revealed that mood was not included in the resident's care plan.

Interview with staff confirmed that there are concerns related to mood for resident # 29 although it is not care planned for the resident.

Registered staff confirmed it is the home's expectation that mood and interventions to improve the resident's mood be care planned for the resident. [s. 6. (1) (a)]

4. Review of the MDS Assessment resident # 27 revealed the RAP for mood state was triggered. The Mood State RAP indicated mood would be care planned.

Review of the Care Plan for resident # 27 revealed the absence of care planning for mood state.

Interview with registered staff confirmed the absence of care planning for mood and confirmed it is the home's expectation that goals and interventions for the resident's mood be included in the resident's plan of care. [s. 6. (1) (a)]

5. Licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of the MDS Assessment for resident # 29 revealed the resident has communication difficulties.

Review of the Care Plan for resident # 29 revealed the resident's did not include interventions to assist resident in communicating.

Interview with the staff revealed the absence of interventions in the resident's plan of care related to communication.

The registered staff confirmed it is the home's expectation that the resident's plan of care include interventions regarding the resident's impaired ability to express them self. [s. 6. (1) (c)]

6. Record review of the Care Plan and the Kardex for resident # 4 revealed the intervention for oral care did not provide clear direction to staff.

Interview with PSW revealed resident # 4 receives oral care both in the morning and before bed from PSW staff.

Interview with registered staff confirmed the oral care intervention outlined in the care plan does not provide clear direction to staff who provide oral care to resident # 4. [s. 6. (1) (c)]

7. Observation of resident # 28 on July 28, 2014 revealed the resident was lying in bed with bilateral padded side rails in use.

Review of the annual MDS Assessment for resident # 28 revealed the resident does not use side rails.

Review of the Bed Rail Assessment revealed the resident uses bilateral 3/4 side rails at the resident's request for safety.

Review of the resident's Care Plan revealed the resident uses bilateral 3/4 side rails.

Interview with a PSW revealed the resident's plan of care does not include that the resident uses padded side rails.

Interview with registered staff confirmed that the resident's plan of care does not provide clear direction; that the resident's assessments are inconsistent and do not include the use of padded side rails.

The registered staff confirmed that the use of padded side rails should be included in the resident's plan of care.

8. Record review of the "Ont - Bed System Assessment June/14" for resident # 16 revealed "side rails removed" and "Care Plan updated."

Record review of the Care Plan in PointClickCare revealed the use of bed rails for bed mobility, however the Care Plan focus for falls outlined an intervention where no bed rails are used.

Observation of the resident's room revealed a sign indicating 2 side rails used as depicted in the picture posted. Observation of the bed system for resident # 16 revealed the bed was absent of side rails and the right side of bed was against the wall.

Interview with registered staff revealed the sign posted in the resident's room regarding the use of side rails is confusing and does not provide clear direction to staff caring for resident # 16 and shared that the information is contradictory since one sign states side rails are used and another sign stated "No bed rails."

The registered staff confirmed that it is the home's expectation that the plan of care have clear direction to all staff and be up to date at all times. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Wound Care Policy instituted or otherwise put in place, is complied with.

Review of the home's "Wound Care" Policy (LTCE-CNS-1-3) revealed:
- "Weekly all wounds will be reassessed with the reassessment being documented on the Wound Care Record" and
- "Completion of wound care/skin care treatments are to be documented on Treatment Administration Records and Wound Care Records."

Review of the Treatment Administration Record (TAR) for resident # 29 revealed that the resident is to have weekly wound assessments.

Review of the TAR for resident # 29 revealed weekly wound assessment and dressing changes were not documented.

Interview with the Wound Care Nurse (WCN) confirmed the resident did receive a

wound assessment and dressing changes, however the WCN did not document the dressing changes.

Interview with the Administrator confirmed that the Skin and Wound policy should be complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the Pet Authorization policy instituted or otherwise put in place, is complied with.

The "Pet Authorization" Policy (LTCE-RSA-C-12) states, "Prior to a pet visiting in the home, the owner of the pet is required to produce a health certificate for the pet outlining that the pet is free from disease, fleas, heartworm and has current up-to-date vaccination."

Observation on second floor by inspector # 563 and # 522 revealed two dogs visiting resident # 55. Administrator could not account for the two dogs and could not produce vaccination records for these visiting pets.

The Administrator confirmed it is the home's expectation to have current vaccination records for all visiting pets. [s. 8. (1)]

3. The licensee failed to ensure that the "Weights and Heights – Resident’s" policy instituted or otherwise put in place, is complied with.

Review of the clinical record for resident # 29 revealed the resident was not weighed five times in 2013 and three times in 2014.

Review of the home’s "Weights and Heights – Resident’s" policy (NUR-V-118) revealed weights are taken on a resident’s bath day during the first week of the month.

Review of the resident’s clinical record revealed the absence of documentation related to the resident not receiving a monthly weight.

The registered staff confirmed that resident # 29 did not receive a monthly weight and confirmed it is the home's expectation that all resident’s receive a monthly weight. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Skin and Wound Policy is complied with and Pet Authorization policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation of the Cozy Nook Lounge and Fireside Lounge on July 28, 2014 revealed the lounges did not have a resident/staff call system.

Staff interview with the Administrator confirmed both lounges are used by residents and that there was not a resident/staff call system accessible to residents.

The Administrator confirmed it is the home's expectation that a resident/staff communication and response system be accessible to residents at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

Observation of the bed system for resident # 28 revealed the resident used an air mattress. Further observation revealed the air mattress was not strapped to the bed frame and when the mattress shifted on the bed frame the hose detached from the hose fitting outlet on the mattress.

This was confirmed by the Acting Director of Care and the Registered Practical Nurse.

Review of Moxi Enterprises Low Air Loss Mattress System manual for the bed system for resident # 28 revealed the mattress cover is to be strapped to the bed frame using the four straps located on each side of the mattress cover.

Interview with the Environmental Manager confirmed it is the home's expectation that the air mattress should be strapped to the bed frame as per manufacturer's instructions. [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 29 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the clinical record for resident # 29 revealed the resident had a pressure ulcer.

Further review of the resident's clinical record revealed an order on the Treatment Administration Records (TAR) for a weekly wound assessment by the wound care nurse.

Review of the skin and wound assessments revealed the resident did not receive a wound assessment or a skin assessment.

The registered staff confirmed the resident did not receive weekly skin and wound assessments as ordered.

The Acting Director of Care (ADOC) confirmed the expectation that the resident receives weekly skin and wound assessment as ordered. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to serve food at a temperature that is both safe and palatable to the residents.

During Stage 1 of the inspection resident # 30 stated "Sometimes the food is not out fast enough and the food does not stay hot; not sure if it is microwaved."

During the observation of the lunch meal service in the second floor dining room, the inspector asked the Dietary Aide to check temperatures of food prior to the end of the meal service. Dietary Aide confirmed that the temperature of the diced potatoes was 100F.

Review of the Food Temperature Sheet prior to the start of the meal service revealed

the temperature of the diced potatoes was 159F.

Interview with the Dietary Aide confirmed that the well in the steam table had not been working properly and no interventions were put in place to ensure the hot food was holding at the required temperature of greater than 140F.

Review of the home's "Food Temperatures" Policy (LTCE-FNS-D-02) revealed that food temperature will be taken during the cooking process and before meal service to residents to ensure that food is maintained at a safe temperature. Safe food temperature range for hot holding is 140F or greater.

Interview with the Administrator confirmed that she was aware that the well in the steam table in the second floor servery was not functioning properly. The Administrator confirmed that no interventions were put in place to ensure the holding temperature of the hot food was greater than 140F.

The Administrator confirmed it is the home's expectation that the holding temperature for hot food should be greater than 140F and hot food should not be served to residents if it is below 140F. [s. 73. (1) 6.]

2. The licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Observation of the 1st floor dining room on July 28, 2014 at 1230 hrs. revealed a resident being served a hot meal at 1245 hrs. Staff did not provide the assistance required by the resident until 1300 hrs.

The Administrator confirmed that it is the home's expectation that residents who require assistance not be served their meal until someone is available to provide the required assistance. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to serve food at a temperature that is both safe and palatable to the residents and to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interview with the Administrator confirmed that the home's Infection Prevention and Control Program was not evaluated and updated this year in 2014. The last Infection Prevention and Control Program evaluation completed annually was conducted on March 13, 2013.

The Administrator shared it is the home's expectation that the annual evaluation of the Infection Prevention and Control Program occur in the spring of each year and the that this year the evaluation did not take place. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participate in the implementation of the program.

Observation of shared bathrooms revealed multiple incidents of bed pans lying on the floor in multiple shared bathrooms. The Acting Director of Care confirmed the home's expectation is that all bed pans used by residents must be stored in a clean manner off the floor. [s. 229. (4)]

Observation of shared bathroom revealed several used and unlabelled personal care items.

Interview with staff revealed that the PSW was unable to state where the bedpans should be stored when not in use.

Staff confirmed that it is the home's expectation that all resident personal care items have identifying labels.

Management confirmed that is the home's expectation that personal equipment be stored on the bathroom shelves when not in use. Work is in progress by the Environmental Services Manager to purchase wall units for all resident bathrooms to store bedpans.

ADOC confirmed that is the home's expectation that all resident personal care items be clearly labelled. ADOC has already assigned staff to complete the task of labelling resident items.

Observation of the 1st floor dining room revealed:
- Dietary Aide was not using proper hand washing when removing dirty dishes from the resident tables prior to serving the next course,
- PSW was wiping their hands on their apron, and
- PSW was feeding a resident with their fingers and scraping food from a residents face with a spoon during the resident's meal.

Administrator confirmed that it is the home's expectation that staff utilize proper hand washing while providing resident care. [s. 229. (4)]

4. Observation of resident # 26 revealed a staff member picking up the resident's hearing aide off the common room floor and placing it back into the resident right ear without cleaning the hearing aide. [s. 229. (4)]

Interview with the Assistant Director of Care (ADOC) confirmed findings and shared it is the home's expectation that all resident personal care items and towel bars should be labelled. The ADOC also confirmed urinals, bed pans and collection hats should be labelled and should not be stored in the resident shared bathrooms. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of "Resident's Council - Recommendations/Concerns" forms between January and April 2014 revealed the home did not respond in writing within 10 days of concerns raised at the Resident's Council (RC) meetings.

The Administrator confirmed a written response to concerns regarding laundry being placed in wrong rooms raised at the January 31, 2014 meeting was not completed within 10 days of the January meeting. Administrator's response dated March 27, 2014.

The Administrator confirmed a written response to concerns regarding missing clothing raised at the February 26, 2014 meeting was not completed within 10 days of the February RC meeting. Administrator's response dated March 27, 2014.

The Administrator confirmed a written response to concerns regarding odour on second floor raised at the March 27, 2014 meeting was not completed within 10 days of the March RC meeting. Director of Care (DOC) response dated April 21, 2014.

Staff interview with the Administrator on July 31, 2014 at 1525 hrs. revealed it is the home's expectation that a written response to concerns raised at Resident Council be completed within 10 days. [s. 57. (2)]

Issued on this 28th day of August, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), JULIE LAMPMAN (522), NANCY JOHNSON (538)
Inspection No. / No de l'inspection :	2014_303563_0024
Log No. / Registre no:	L-000878-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 25, 2014
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	CHATEAU GARDENS ELMIRA LONG TERM CARE CENTRE 11 Herbert Street, Elmira, ON, N3B-2B8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HELEN RICHARD

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must achieve compliance to ensure when bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. O.Reg. 79/10, s. 15 (1) (b).

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s. 15 (1) (b).

The plan must include immediate and long term actions to be implemented to ensure all resident bed systems where bed rails are used pass zones of entrapment and the actions taken to correct the identified deficiencies, who will be responsible to correct the deficiencies and the dates for completion.

The bed system audit must specify the following for all residents audited for bed entrapment:
a) Resident room and bed number
b) Mattress date
c) Date bed system was tested
d) Pass or fail for entrapment zones
e) Corrective action taken and date to address fails
f) Re-evaluation of any bed system that has been modified in any way and date

Please submit the plan, in writing, to Melanie Northey, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, be email to melanie.northey@ontario.ca by September 8, 2014.

Date to be complied October 6, 2014.

Grounds / Motifs :

1. The licensee failed to ensure where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. Observation of the bed system on July 28, 2014 at 1330 hrs. for resident # 53 revealed one half rail in use on the left side of the bed and keepers absent from the foot of the bed.

Interview with the Environmental Manager on July 28, 2014 at 1430 hrs. confirmed resident # 53 bed system does not have mattress keepers affixed to

the foot of the bed frame and keepers should be installed to prevent the mattress from slipping.

Record review of the "Bed Entrapment Log" for resident # 53 revealed a corrective action of "4 keepers" dated February/2014. Only the head of the bed had keepers in place on July 28, 2014.

Environmental Manager added keepers to the foot of the bed on July 28, 2014 for resident # 53.

B. Observation of the mattress on July 29, 2014 for resident # 15 revealed that the mattress did not fit the bed properly. The mattress was too large and did not stay stationary within the keepers.

Record review of the "Facility Entrapment Inspection Sheet" for resident # 15 dated November 14, 2012 revealed fails in zones 2 and 4 where the home identified "rail older matt" as the reason for failure.

The "Bed Entrapment Log" dated February/2014 revealed a corrective action of "4 keepers" and the "Bed Entrapment Log" dated July 24, 2014 revealed no corrective action to replace the old mattress.

The Acting Director of Care confirmed the mattress for resident # 15 was too large for the bed and an entrapment risk to the resident. The Administrator confirmed that the bed was a risk for resident bed entrapment.

C. Observation of air mattress on July 28, 2014 at 1400 hrs. for resident # 3 revealed it did not fit the bed frame and there was a gap greater than 4.5 " between the head board and the mattress of the bed.

Observation on July 28, 2014 at 1600 hrs. revealed the air mattress for resident # 3 had been fixed so that the air mattress fits the frame of the bed. (538)

D. Record review of the "Facility Entrapment Inspection Sheet" dated November 14, 2012 revealed multiple fails in zones 2, 3 and 4 for multiple residents where the home identified "older matt" as the reason for most of these failures.

Record review of the "Bed Entrapment Log" revealed corrective action was completed February 2014 and July 24, 2014. This was 15 - 20 months after the

failed bed systems were identified. No documentation of corrective actions taken after the November 14, 2012 entrapment inspection.

Observation of the "Facility Entrapment Inspection Sheet" and the "Bed Entrapment Log(s)" revealed once corrective action was taken, an inspection for bed entrapment was not completed to ensure interventions were effective in correcting the failed zones identified on the November 14, 2012 inspection sheet.

Documentation provided by the Environmental Manager proved inconsistent across all bed entrapment logs given to inspector # 563 on July 28, 2014. For example, the documentation for the bed system in room S201 bed 4 revealed:
- the "Facility Entrapment Inspection Sheet" dated November 14, 2012 identified the mattress had 4 keepers and the reason for the fail in zone 2 and 4 was due to “older matt”
- the "Bed Entrapment Log" dated “Feb/14” indicates a corrective action of “4 keepers”
- the "Bed Entrapment Log" dated July 24, 2014 indicates a pass in only zone 4 with no documented corrective action.

It was unclear in the documentation provided that steps were taken to prevent resident entrapment in all bed systems and that after corrective action was taken each bed system was re-evaluated to ensure safety for the resident. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 06, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

Service Area Office /
Bureau régional de services : London Service Area Office